MDR: M4-02-5032-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $848.97 for dates of service, 5/15/02 and 5/17/02.

   b. The request was received on 8/19/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Position Statement taken from the Table of Disputed Services
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Example EOBs from various Carriers
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 10/09/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 10/10/02. The response from the insurance carrier was received in the Division on 11/08/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request.

3 Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Taken from Table of Disputed Services

   "We the provider are requesting full payment on [sic] the D.M.E. provided to this patient. We have billed this equipment at a fair & reasonable rate and no negotiations or request for a reduced purchase price was made. We have provided the carrier with examples of payments made by other carriers for the exact equipment paid at the full billed amount. We are now requesting the remaining balance in full."

2. Respondent:

   The response was not timely and consequently not eligible for review.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 5/15/02 and 5/17/02.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $5,275.00 for services rendered on the dates of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $4,426.03 for services rendered on the dates of service in dispute above.

5. The Carrier's EOBs deny additional reimbursement as "M – REDUCED TO FAIR AND REASONABLE; O – DENIAL AFTER RECONSIDERATION."

6. The amount in dispute is $848.97 for services rendered on the dates of service in dispute above.

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
5/15/02	E1399 Cold Therapy Cooler Wrap E1399 Water Circulating Pad E1399 Auto Adapter	$75.00 $155.00 $45.00	$52.99 $113.04 $10.00	M, O for all DME	No MAR	TWCC Act & Rules Sec. 413.011 (d) and MFG DME IV	The Carrier has denied the dates of disputed service, as "M-REDUCED TO FAIR AND REASONABLE". The provider has included in their dispute packet, documentation (EOBs from other carriers) that provides some evidence of "fair and reasonable" reimbursement. Since there is no MAR, the Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence as to whether the billed amount is fair and reasonable. However, the Carrier failed to submit a response in a timely manner and consequently it is not eligible for review. Therefore, the Carrier has not submitted any evidence of the methodology it used to determine fair and reasonable reimbursement. The provider has submitted EOBs that do show some evidence of fair and reasonable. Therefore, additional reimbursement **is** recommended in the amount of **$98.97.** ($275.00 billed amount - $176.03 already paid = $98.97.)

5/17/02	E0748-NU	$5,000	$4,250.00	M, O	No MAR	MFG GI VIII	MFG GI VIII states "…NOTE: TWCC modifiers may differ from those published by the American Medical Association, and in submitting workers' compensation billing, only the modifiers set out in this Medical Fee Guideline shall be used…" The modifier "-NU" is not recognized in the '96 MFG. For this reason, the Medical Review Division is unable to determine proper reimbursement. Since "-NU" is an unrecognized modifier, **no** additional reimbursement is recommended.
Totals		$5,275.00	$4,426.03				The Requestor **is** entitled to reimbursement in the amount of **$98.97.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$98.97** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 14th day of April 2003.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division

PD/pd